ST. TERESA ACUPUNCTURE WELLNESS CLINIC
1920 Hollister Road • Houston, Texas 77080

Authorization For Release Of Protected Health Information

Patient named below hereby authorizes St. Teresa Acupuncture Wellness Clinic to disclose patient's protected health information to the designated person/organization listed below.

Patient's Name: ________________________________ Phone: ______________________

Address: ____

City, State, Zip Code: ____

DISCLOSE INFORMATION TO:

____ Phone: _____________________

(Name of Person / Organization)

Dept / Contact Person: ____

Address: ____

City, State, Zip Code: ____

☐ Patient authorizes the disclosure of all medical records.

☐ Patient authorizes the disclosure of only certain medical records *(please specify):*

____

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Other instructions: ____

____

# of copies requested: ____

Fees:

- First copy - no charge
- Each additional copy - $6.00

☐ Mail to recipient's address listed above.

☐ Mail to patient's address.

☐ Pick up by patient or representative.

Signature ____________________________________ Date ____________________

Patient (or Patient's Representative)

Representative of patient (PRINT NAME): ___________________________________